

Dental and Dental Plus

Dental and Dental Plus

Table of Contents

Introduction.....	93
Your Dental Benefits at a Glance.....	94
Claim Examples (using Class III procedure claims).....	95
How to File a Dental Claim	95
Special Provisions of the State Dental Plan	96
Dental Services not Covered	96
Appeals.....	98
Coordination of Benefits.....	98

Introduction

Keeping your teeth healthy is important to your overall health. That is why we offer the State Dental Plan and Dental Plus, a supplemental dental program. To participate in Dental Plus, you must be enrolled in the State Dental Plan, and you must have cover the same family members under both plans.

State Dental Plan

The State Dental Plan offers these levels of treatment: diagnostic and preventive, basic, prosthodontics, and orthodontics. They are described on page 94. The benefit for orthodontics is limited to a \$1,000 lifetime benefit for each covered child.

The yearly maximum for the State Dental Plan alone is \$1,000 for each subscriber or covered dependent. The deductibles under the State Dental Plan are \$25 annually for each subscriber or covered dependent for dental services under Class II and Class III. The maximum deductible for family coverage is for three persons, or \$75.

Dental Plus

Dental Plus covers the first three levels of service at the same percentage of coverage as the State Dental Plan. However, the allowance is higher. **Dental Plus does not cover orthodontics.**

Under Dental Plus, reimbursement is based on what your dentist charges, up to the maximum Dental Plus allowance.

This means that reimbursement for your dental expenses may fall within these allowances, and you may only be responsible for paying the deductible and coinsurance. If your dentist charges more for covered services than Dental Plus allows, **you will be responsible for paying the difference** unless your dentist has agreed to accept the Dental Plus allowance.

The Employee Insurance Program (EIP) offered agreements to all South Carolina dentists to accept the lesser of their usual charges or the Dental Plus maximum allowances. To find the list of dentists that have accepted the agreement, go to the EIP Web site, www.eip.sc.gov:

- Select “Links,” and then “State Dental Plan/Dental Plus.”
- Click on “BlueCross BlueShield of SC.”
- Under “Find a Doctor,” select “South Carolina” Under “Healthcare Professional Type, select “Dentists.”
- Under “Select a Health Plan,” choose “State Dental Plus.”
- Under “Select a Specialty,” you can choose either “Dentist” or “Oral Surgeon.”

If your dentist has not accepted EIP’s agreement, your level of benefits under Dental Plus will not be reduced. However, you will be responsible for the difference between your dentist’s charge and the Dental Plus allowed amount.

The **combined** maximum yearly benefit for both the State Dental Plan and Dental Plus is \$1,500 for each subscriber or covered dependent. There are no additional deductibles and coinsurance under Dental Plus.

Your Dental Benefits at a Glance

Not all dental procedures are covered. Reimbursement is based on the lesser of the dentist's actual charge or the plan's allowed amount. Please see pages 95-97 for more information.

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	State Dental Plan	None	100% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	None	100% of allowed amount or actual charge	\$1,500 ² per person each benefit year combined for Classes I, II and III
II Basic Benefits	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures	State Dental Plan	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	80% of allowed amount after State Dental Plan deductible is met	\$1,500 ² per person each benefit year combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	State Dental Plan	\$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		Dental Plus	No additional deductible	50% of allowed amount after State Dental Plan deductible is met	\$1,500 ² per person each benefit year combined for Classes I, II and III
IV Orthodontics¹	Limited to covered children under age 19 Correction of malocclusion Consisting of: diagnostic services (including models and X-rays) Active treatment (including necessary appliances)	State Dental Plan	None	50% of allowed amount	\$1,000 lifetime benefit for each covered child
		Dental Plus	Dental Plus does not cover orthodontic services.	Dental Plus does not cover orthodontic services.	Dental Plus does not cover orthodontic services.

¹ A subscriber must submit a letter from his provider for the subscriber's eligible dependent up to age 19 stating that the orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

² \$1,500 is the total yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

CLAIM EXAMPLES (USING CLASS III PROCEDURE CLAIMS)

Under the State Dental Plan and Dental Plus, Class III dental benefits, prosthodontics, are paid at 50 percent of the allowed amount after the deductible is paid. The table below illustrates how the two plans work together using a crown (resin with predominant base metal) as an example.

Description	Dollar Amount
Dentist's charge	\$680
State Dental Plan allowed amount	\$349
State Dental Plan payment (50% of the allowed amount)	\$174.50
Subscriber enrolled only in the State Dental Plan pays	\$505.50
Dental Plus allowed amount	\$686
Total payment for subscriber enrolled in State Dental Plan and Dental Plus (The Dental Plus payment is 50% of the dentist's charge or 50% of the allowed amount, whichever is less)	\$340 (this includes the State Dental Plan payment of \$174.50 and the Dental Plus payment of \$165.50)
Subscriber enrolled in Dental Plus pays	\$340
Additional benefit with Dental Plus	\$165.50

HOW TO FILE A DENTAL CLAIM

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, you must show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file claims for you, you can file them with BlueCross BlueShield of South Carolina. See page 214 for information on how to file a dental claim.

If you are covered under Dental Plus, BlueCross BlueShield will process your dental claims under the State Dental Plan and then under Dental Plus. You do not have to submit any additional claims.

SPECIAL PROVISIONS OF THE STATE DENTAL PLAN

Alternate Forms of Treatment

If you or your dentist select a more expensive or personalized treatment, benefits will be allowed for the less costly procedure consistent with sound professional standards of dental care. BlueCross BlueShield of South Carolina uses guidelines based on usual and customarily provided services and standards of dental care to determine benefits and/or denials.

Voluntary Pre-authorization

Although it is not required, EIP suggests that you pre-authorize your non-emergency treatment if you have estimated charges of \$500 or more. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina, State Dental Claims Department, P.O. Box 100300, Columbia, SC 29202-3300.

You and your dentist will receive a Predetermination of Benefits form, which will show what part of the expenses your dental plan will cover. This form can be used to file for benefits as the work is completed. Just fill in the date(s) of service, sign the form, have your dentist sign the form and submit it to BCBSSC. Your pre-authorization is valid for one year from the date of the form. However, the date of service may affect your benefits. For example, if you have reached your maximum benefit when you have the pre-authorized service performed, you will not receive the amount that was approved on the Predetermination of Benefits form.

Emergency treatment does not have to be pre-authorized.

DENTAL SERVICES NOT COVERED

There are some dental services the State Dental Plan and Dental Plus do not cover. The dental plan document, which is available in your benefits administrator's office, lists all these exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General Services not Covered

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered when performed under the supervision and direction of a dentist.
- Services beyond the scope of the dentist's license.
- Services performed by a dentist who is a member of the covered person's family and for which the covered person was not previously charged or did not pay the dentist.
- Dental services or supplies that are rendered before the date you are eligible for coverage under this plan
- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss).
- Non-dental services, such as broken appointments and completion of claim forms.
- Nutritional counseling for the control of dental disease, oral hygiene instruction and training in preventive dental care.
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit.
- Services or supplies not recommended or approved by the attending dentist.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Services Covered by Another Plan

- Treatment for which the covered person is entitled under any Workers' Compensation law.
- Services or supplies that are covered by the armed services of a government.
- Services or supplies that are furnished in a U.S. government facility (or its agent) or by a doctor employed by such a facility.

Specific Procedures not Covered

- Space maintainers for lost deciduous teeth if the dependent is age 19 or older.
- Experimental services or supplies.
- Onlays or crowns, when used for preventive purposes or due to erosion, abrasion, or attrition.
- Services and supplies for cosmetic or esthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction of temporomandibular joint (TMJ) syndrome.
- Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition.
- Splinting or periodontal splinting, including extra abutments for bridges.
- Services for these tests and laboratory examinations: bacterial cultures for determining pathological agents, caries (tooth or bone destruction), susceptibility tests, diagnostic photographs and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete).
- Services for temporary repair of fractured teeth.
- Rebase procedures.
- Implants and related services, including prosthodontics (crowns and abutments) placed on implants.
- Stress breakers.
- Precision attachments.
- Temporary procedures that are considered part of a more definitive treatment.
- Inlays (cast metal and/or composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.

Limited Services

- More than two of these procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis.
- More than two periodontal prophylaxes (available only to patients who have a history of periodontal surgery). Two periodontal prophylaxes may be performed in addition to two prophylaxes provided above.
- Bitewing X-rays more than twice during any plan year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist.
- More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year.
- Topical application of sealants per tooth for patients age 16 and older. For patients age 15 and younger, payment is limited to one treatment every three years and applies to permanent unrestored molars only.
- More than one root canal treatment on the same tooth. Additional treatment should be submitted with the appropriate American Dental Association procedure code and documentation.
- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing.
- Bone replacement grafts performed on the same site more than once in any 36-month period.
- Additional sites in excess of two bone replacement grafts performed on the same day. (Payment is limited.)
- Periodontal scaling for treatment of gingival inflammation if performed more than once per lifetime.
- Tissue conditioning for upper and lower dentures if performed more than twice per unit in any 36-month period.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations is not considered a separate benefit.
- There is a five-year replacement limitation for cast restoration and prosthodontics.
- The application of desensitizing medicaments is limited to two times per quadrant per year.
- No more than one composite or amalgam restoration per surface in a 12-month period.
- Replacement of existing cast prosthodontics, including crowns, partial or full removable dentures or fixed bridgework, or addition of teeth to an existing partial, removable denture or bridgework, unless evidence is submitted and is satisfactory to the administrator that: (1) the addition of teeth is required for the initial replacement of one or more natural teeth; (2) the existing denture or bridgework was installed at least five years prior to its replacement or that the existing denture or bridgework cannot be made serviceable; or (3)

the existing denture is an immediate temporary denture, and replacement by a permanent denture is required, and that such replacement is delivered or installed within a period of 12 consecutive months following the date of replacement of the immediate temporary denture.

Prosthodontic and Orthodontic Services

- Prosthodontics (including bridges and crowns) and their fitting that were ordered while the person was covered under the plan, but were installed or delivered more than 90 days after termination of coverage.
- Replacement of lost or stolen prosthodontics, space maintainers or orthodontic appliances or charges for spare or duplicate dentures or appliances.
- Replacement of broken orthodontic appliances.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees and covered children ages 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month your dependent becomes ineligible for coverage.

Please note: Dental Plus does not cover orthodontic services.

APPEALS

If BlueCross BlueShield of South Carolina (BCBSSC) denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this book or call for an explanation. If you are unsure the decision was fair, you can ask BCBSSC to re-examine the denial of your claim or proposed treatment. The request for review should be made in writing within six months after notice of the decision.

If you are still dissatisfied after BCBSSC has reviewed the decision, you have 90 days to request, in writing, that the Employee Insurance Program (EIP) review the decision. If the denial is upheld by EIP, you have 30 days to seek review in the Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

COORDINATION OF BENEFITS

If you are covered by more than one dental plan, you may file a claim for reimbursement from both plans. Coordination of benefits is a system that allows administrators of both plans to work together to give you the maximum benefit allowed. However, you will never receive more than 100 percent of your covered dental expenses.

For detailed information about coordination of benefits, including how to determine which plan pays first, see page 17. If your state dental coverage is secondary, you must send the explanation of benefits you receive from your primary plan with your claim to BCBSSC.

If you have questions, contact BCBSSC toll-free at 888-214-6230, your benefits office or EIP.



For information about what to do when your State Dental Plan coverage ends, please refer to the General Information chapter on page 16.